STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155741	A. BUILDING _____ B. WING _____	C 01/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTHCARE	2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00084353 and IN00084613. Complaint IN00084353-Substantiated, federal and state deficiencies related to the allegation are cited at F323. Complaint IN00084613- Substantiated, federal and state deficiencies related to the allegation are cited at F323. Survey date: January 20, 21, and 24, 2011 Facility number: 004700 Provider number: 155741 AIM number: 100266630 Survey Team: Joyce Hofmann, RN Census bed type: SNF/NF: 44 Total: 44 Census payor type: Medicare: 4 Medicaid: 37 Other: 3 Total: 44 Sample: 4 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed on January 25, 2011 by Bev Faulkner, RN	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

RECEIVED
FEB - 2 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

2/4/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Daniel J Gallagher HFA	Assistant Administrator	2/2/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident received adequate supervision to prevent an accident that resulted in the resident having received a subdural hematoma for 1 of 4 residents reviewed for falls in a sample of 4. [Resident #A] Findings include: Initial tour of the facility was made on 01/20/2011 at 1:05 p.m., with the wound care nurse, LPN #1. LPN #1 indicated through interview Resident #A was a new resident, was totally dependent, had a history of CVA [cerebrovascular accident] and a recent fall with a concussion and laceration to right eye orbit. Resident #A's clinical record was reviewed on 01/21/11 at 12 p.m., and indicated the resident was admitted on 12/11/2010 and had prior hospitalization from 11/23/10 to 12/11/10 for an urinary tract infection. Diagnoses included, but were not limited to, dementia, diabetes, coronary artery disease, chronic kidney disease, congestive heart failure, peripheral artery disease, peripheral vascular disease, urinary tract	F 323	Resident #A has had a new fall risk assessment completed. Resident #A's care plan and the C.N.A. assignment sheet have been updated to reflect interventions that are in place to prevent falls. The interventions include a wedge cushion, a tilt back wheelchair, and a personal safety alarm. We have also ordered a protective helmet for therapy to evaluate. C.N.A. #1 was counseled regarding resident safety, and was given a written warning for leaving Resident #A unattended while she went to find another staff member to help with his transfer. The LPN on duty and the RN on duty at the time of Resident #A's fall also received written warnings related to that event. New fall risk assessments have been completed on all residents within the facility. As a result of those assessments, 19 residents have been identified as being at risk for falls. All residents who are identified as being at risk for falls have the potential to be	

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F 323	Continued From page 2 infection, cerebral vascular accident, and most recent subdural hematoma. The resident was noted to have medication orders for Lasix [a diuretic], Depakote [an anticonvulsant], Neurontin [an anticonvulsant], Trazodone [an antidepressant], Lexapro [an antidepressant], and Lopressor [an antihypertensive]; all that put the resident at risk for falls. Resident #A's admission nursing assessment, dated 12/11/10, indicated an altered mental status, poor muscle strength, Hoyer lift, edema in feet and hands, and care plans for altered mental status and fall risk. The fall risk assessment of the admission nursing assessment had circled intermittent confusion, chair fast, problems with standing, walking, muscular coordination, and problem with doorways, medication change in the last 5 days, and predisposing diseases. The fall risk scoring lacked totals, but would have been a score of 15, which put the resident at high risk for potential falls as a total score of 10 or above is considered high risk. The initial care plan for fall risk had approach to remind the resident to use call light with a goal of no falls. The resident's care plan for "Potential for injuries from falls due to inability to stand and transfer self..." with original dated 12/22/10 had interventions of the following: "*Staff to assure environment is free of wet spots and small items placed low on floor *Assure that lighting is adequate *Monitor for side effects from medications, labs, appetite as cause for falls * call light available and answered promptly *Monitor resident for steadiness and balance *Discourage resident from abrupt position change."	F 323	affected. All residents identified as being at risk for falls have had their care plans and C.N.A. assignment sheets reviewed and updated to ensure that interventions are in place for fall/accident prevention. An all staff inservice was given 1/28/2011 on falls/accidents, and the importance of following care plans and C.N.A. assignment sheets to prevent injury to residents. The DON counseled all charge nurses as to their responsibility to promptly implement interventions to prevent falls and accidents. The interdisciplinary team met with therapy to review our policy & procedure regarding fall prevention. The interdisciplinary team will review falls once weekly to ensure that interventions are implemented to prevent injury to residents. Additionally, falls and accidents will be reviewed in Quality Assurance meetings quarterly to	

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F 323	Continued From page 3	F 323	evaluate the effectiveness of our fall prevention program.	

Incidents and accidents reported to the state agency were reviewed on 01/20/11 at 2:10 p.m., and indicated an incident involving Resident #A had been reported. The incident occurred on 01/01/11 at 6 p.m., when the resident fell forward out of his wheelchair and sustained a laceration to his right eyebrow with profuse bleeding and a subdural hematoma. The report indicated the resident was sent to the hospital and admitted.

The Administrative Investigation Report, dated 01/04/11, indicated the resident had spent most of supper time leaning forward in his Broda chair and had attempted to scoot forward in his chair. Staff had to reposition the resident numerous times during supper. After supper, the resident was wheeled into the main hallway in front of the lobby by CNA #1 who then left the resident and walked down the hall to ask another staff to help put him to bed. The resident wanted to go to the lobby and attempted to scoot himself in his chair, which resulted in him falling forward and hitting his head.

A written statement by CNA #1 indicated she started her shift at 2 p.m. and was asked by the nurse to get the resident up and she did so around 4 p.m. and put him in his wheelchair and took him to the main dining room for dinner. During dinner, the resident kept leaning forward onto the table and staff kept repositioning him. After dinner, CNA #1 removed the resident from the main dining room and placed his wheelchair in the hall. CNA #1 left the resident to get LPN #2 to help her and as soon as she turned around the resident was on the floor. CNA #1 and LPN #2 ran to the resident to check on him. Staff was only away from the resident for less than 1 minute according to the written statement. This

The Director of Nursing, Administrator, and Assistant Administrator are responsible for compliance.

Date of completion 2/02/2011

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F 323	Continued From page 4	F 323		

statement was signed by CNA #1 and dated 01/05/11.

A written statement by the Director of Nursing [DoN], dated 01/04/11 at 12 p.m., indicated LPN #2 told her Resident #A had been leaning forward in his chair for much of the day. They reclined his chair a bit, but he was still leaning forward and attempting to get out of it. LPN #2 left the dining room and went to the South Nurse's Station when a few minutes later another resident yelled that Resident #A was on the floor in the hallway. LPN #2 indicated to the DoN she was unsure who pushed Resident #A into the hallway.

A written statement by the DoN, dated 01/05/11 at 11 a.m., indicated the DoN asked Resident #A if he could remember what happened the other night when he fell and the resident stated, "Yeah, I was trying to go into that front room and I fell." The DoN asked if he was walking to the front room and the resident responded, "No, I can't walk I use a wheelchair."

The Incident Report indicated Resident #A was evaluated for positioning in his wheelchair by therapy and a wedge cushion was to be used to ensure the resident did not scoot forward in his chair and a personal safety alarm was placed on the resident when he is in bed and up in his wheelchair.

Review of the Occupational Therapy Positioning Evaluation, dated 01/06/11, indicated the reason for referral was the "Patient fell and injured face. Nursing reports fall occurred from wheelchair when patient was not attended." The evaluation indicated the resident's present wheelchair was adequate for all needs with good positioning for

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daily activities and use a wedge cushion for increased safety and fall prevention. The evaluation also indicated the patient was also tested for sitting ability using the patient's standard cushion and the patient did not express/demonstrate any safety issues. Patient demonstrated good sitting balance and posture. The wedge cushion was introduced at the time per DoN request.

Discharge recommendations were the following: "We request the nursing staff to provide on going supervision when patient is in the wheelchair."

Interview with CNA #1 on 01/24/11 at 12:10 p.m., indicated she came in to work at 2 p.m. the day of the fall. CNA #1 indicated Resident #A had not been gotten up all day and she was told to get him up. CNA #1 indicated she got him about 3:30 p.m., and took him to the dining room and placed him at the feed table. LPN #3 told her Resident #A kept leaning forward during dinner, which was unusual for Resident #A as he usually leaned to the side. CNA #1 indicated she removed Resident #A from the dining room after dinner to the hallway and he started propelling himself and she left him to get LPN #2 to help put him to bed. CNA #1 indicated as soon as she turned around, he (the resident) was on the floor and he had his hand under his head and lying on his right side kind of on his stomach. LPN #2 told her to call 911 and she and LPN #2 rolled him over to his back and the LPN #2 assessed the resident and he was bleeding from his right eyebrow and ended up with stitches. CNA #1 indicated the resident was not acting like his normal self prior to the fall as he normally tells you about Evansville and can make his needs known. CNA #1 indicated Resident #A transfers with a stand

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F 323	Continued From page 6	F 323		

up lift and now has a personal safety alarm after the fall.

Resident #A was observed during lunch meal on 01/21/11 at 12:50 p.m., in the main dining room sitting in his Broda chair being fed by staff. The Broda chair was noted to be tilted back a little.

Observation was made of Resident #A while he was in bed on 01/21/11 at 4:30 p.m., and during interview at this time, the resident indicated he fell in the front room [lobby] and hit his head and pointed to his right eyebrow with his index finger. The resident was noted to have a scar to the right eyebrow lid area. No stitches remained and there was no bruising.

This federal deficiency is related to Complaint IN00084353 and Complaint IN00084613.

3.1-45(a)(2)